CHART: ___________

TSDDC/TGA ACKNOWLEDGEMENT OF PRIVACY NOTICE

I acknowledge that I have been offered the **Privacy Practices Notice.**
(Available at www.tsddc.com or in the office)

____

Patient or Personal Representative's Printed Name

____

Patient or personal Representative's Signature

If personal representative's signature appears above, please describe personal representative's relationship to the patient: ______________________________________

PATIENT RECORD OF DISCLOSURES

I, ____, give my permission to discuss my PHI with the following person (s):

NAME	**RELATIONSHIP**
1.________________________________	___________________________________
2.________________________________	___________________________________
3.________________________________	___________________________________

I wish to be contacted in the following manner (check all that apply):

Home Telephone__________________
____ O.K to leave a detailed message
____Leave just a call back number

Written Communication
____O.K. to mail medical information to the home address

Cell Phone___________________
____ O.K. to leave a detailed message
____ Leave just a call back number

Work Number___________________
____ O.K to leave a detailed message
____ Leave just a call back number

*** If any of this information should change, it is your responsibility as our patient to notify TSDDC/TGA of these changes as soon as possible.**

________________________________	_____________________________	____________
PRINTED NAME	SIGNATURE	DATE